

GEORGIA DEATH CERTIFICATE

State File Number

2021GA000055745

1. DECEASED'S LEGAL FULL NAME (First, Middle, Last) DESMOND DESHAUN MORGAN		1a. IF FEMALE, ENTER LAST NAME AT BIRTH		2. SEX MALE	2a. DATE OF DEATH (Mo., Day, Year) ACTUAL DATE OF DEATH 04/03/2021	
3. SOCIAL SECURITY NUMBER 252-63-1947	4a. AGE (Years) 33	4b. UNDER 1 YEAR Mos. 0	4c. UNDER 1 DAY Days 0	5. DATE OF BIRTH (Mo., Day, Year) 10/30/1987		
6. BIRTHPLACE GEORGIA	7a. RESIDENCE - STATE GEORGIA	7b. COUNTY FULTON		7c. CITY, TOWN ATLANTA		
7d. STREET AND NUMBER 3820 OLD CASCADE ROAD APT O-2		7e. ZIP CODE 30331	7f. INSIDE CITY LIMITS? YES	8. ARMED FORCES? NO		
8a USUAL OCCUPATION TRUCK DRIVER		8b. KIND OF INDUSTRY OR BUSINESS TRANSPORTATION				
9. MARITAL STATUS MARRIED	10. SPOUSE NAME RACHEL ONYEWELEIHI LUCKY			11. FATHER'S FULL NAME (First, Middle, Last) CALVIN NOT STATED		
12. MOTHER'S MAIDEN NAME (First, Middle, Last) CHERYL MORGAN	13a. INFORMANT'S NAME (First, Middle, Last) JACQUELINE MORGAN			13b. RELATIONSHIP TO DECEASED SISTER		
13c. MAILING ADDRESS 3820 OLD CASCADE ROAD APT O-2 ATLANTA GEORGIA 30331			14. DECEASED'S EDUCATION 12TH GRADE COMPLETED BUT DID NOT GRADUATE			
15. ORIGIN OF DECEASED (Spanish/Hispanic/Latino) NO, NOT SPANISH/HISPANIC/LATINO			16. DECEASED'S RACE (White, Black, American Indian, etc.) (Specify) BLACK OR AFRICAN-AMERICAN			
17a. IF DEATH OCCURRED IN HOSPITAL INPATIENT		17b. IF DEATH OCCURRED OTHER THAN HOSPITAL (Specify)				
18. HOSPITAL OR OTHER INSTITUTION NAME (If not in either give street and no.) NORTHSIDE HOSP		19. CITY, TOWN or LOCATION OF DEATH ATLANTA		20. COUNTY OF DEATH FULTON		
21. METHOD OF DISPOSITION (Specify) CREMATION		22. PLACE OF DISPOSITION WEST GEORGIA CREMATORIAL 5756 B HARRISON AVENUE AUSTELL GEORGIA 30106			23. DISPOSITION DATE (Mo., Day, Year) 04/26/2021	
24a. EMBALMER'S NAME FRANK PIPPINS		24b. EMBALMER LICENSE NO. 3175	25. FUNERAL HOME NAME GUS THORNHILLS FUNL HM INC			
25a. FUNERAL HOME ADDRESS 1315 GUS THORNHILL, JR. DRIVE BOX 91384 EAST POINT GEORGIA 30344						
26a. SIGNATURE OF FUNERAL DIRECTOR ANNELL THORNHILL		26b. FUN. DIR. LICENSE NO 3706	AMENDMENTS 8/17/2023 10, 9			
27. DATE PRONOUNCED DEAD (Mo., Day, Year) 04/03/2021	28. HOUR PRONOUNCED DEAD 10:27 AM					
29a. PRONOUNCER'S NAME BISWASHREE CHAUDHURY		29b. LICENSE NUMBER 067401		29c. DATE SIGNED 04/03/2021		
30. TIME OF DEATH 10:27 AM		31. WAS CASE REFERRED TO MEDICAL EXAMINER YES				
32. Part I. Enter the chain of events-diseases, injuries, or complications that directly caused the death. DO NOT enter terminal events such as cardiac arrest, respiratory arrest, or ventricular fibrillation without showing the etiology. DO NOT ABBREVIATE. IMMEDIATE CAUSE (Final disease or condition resulting in death)				Approximate interval between onset and death		
A. MULTIORGAN SYSTEM FAILURE Due to, or as a consequence of PROLONGED DOWN TIME AFTER MULTIPLE EPISODES OF CARDIAC ARREST				DAYS		
B. Due to, or as a consequence of METHAMPHETAMINE TOXICITY				DAYS		
C. Due to, or as a consequence of				DAYS		
D. Part II. Enter significant conditions contributing to death but not related to cause given in Part 1A. If female, indicate if pregnant or birth occurred within 90 days of death.						
33. WAS AUTOPSY PERFORMED? YES		34. WERE AUTOPSY FINDINGS AVAILABLE TO COMPLETE THE CAUSE OF DEATH? YES				
35. TOBACCO USE CONTRIBUTED TO DEATH NO		36. IF FEMALE (range 10-54) PREGNANT NOT APPLICABLE		37. ACCIDENT, SUICIDE, HOMICIDE, UNDETERMINED (Specify) ACCIDENT		
38. DATE OF INJURY (Mo., Day, Year) 03/26/2021	39. TIME OF INJURY 17:03 MILITARY	40. PLACE OF INJURY (Home, Farm, Street, Factory, Office, Etc.) (Specify) RESIDENCE	41. INJURY AT WORK? (Yes or No) NO			
42. LOCATION OF INJURY (Street, Apartment Number, City or Town, State, Zip, County) 506 PHARR ROAD NE APT 201 ATLANTA GEORGIA 30305 FULTON						
43. DESCRIBE HOW INJURY OCCURRED TOXIC EFFECTS OF METHAMPHETAMINE RESULTING IN CARDIAC ARREST			44. IF TRANSPORTATION INJURY NO			
45. To the best of my knowledge death occurred at the time, date and place and due to the cause(s) stated. Medical Certifier (Name, Title, License No.)			46. On the basis of examination and/or investigation, in my opinion death occurred at the time, date and place and due to the cause(s) stated. Medical Examiner/Coroner (Name, Title, License No.) /S/ JACQUELINE ANN MARIE BENJAMIN MD 86558			
45a. DATE SIGNED (Mo., Day, Year) 07/21/2021	45b. HOUR OF DEATH 10:27 AM	46a. DATE SIGNED (Mo., Day, Year) 07/21/2021	46b. HOUR OF DEATH 10:27 AM			
47. NAME, ADDRESS, AND ZIP CODE OF PERSON COMPLETING CAUSE OF DEATH JACQUELINE ANN MARIE BENJAMIN 430 PRYOR STREET ATLANTA GEORGIA 30312						
48. REGISTRAR (Signature) /S/ CHRISTOPHER JP HARRISON			49. DATE FILED - REGISTRAR (Mo., Day, Year) 07/26/2021			